

**TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.5 MAJOR RISK MEDICAL INSURANCE BOARD
MAJOR RISK MEDICAL INSURANCE PROGRAM**

**Article 3. Minimum Scope of Benefits
Amends Section 2698.302**

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Section 2698.302 is amended to read:

§ 2698.302. Excluded Benefits.

(a) Plans offered under this program shall exclude the following benefits unless specifically provided for in the program contract with the participating health plan:

- (1) Services that are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:
 - (A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and
 - (B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and
 - (C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and
 - (D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.
- (2) Any services which are received prior to the enrollee's effective date of coverage.

- (3) Custodial, domiciliary care, or rest cures for which facilities of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
- (4) Personal or comfort items, or a private room in a hospital unless medically necessary.
- (5) Emergency facility services for nonemergency conditions.
- (6) Those medical, surgical (including implants), or other health care procedures, services, drugs, or devices which are either:
 - (A) Services, products, drugs or devices which are experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.
 - (B) Outmoded or not efficacious.
- (7) Transportation except as specified in section 2698.301(a)(5).
- (8) Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in section 2698.301(a)(6).
- (9) Sex change operations, investigation of or treatment for infertility, reversal of sterilization, and conception by artificial means.
- (10) Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery), routine eye examinations, including eye refractions, except when provided as part of a routine examination under "preventive care for minors," hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care are excluded.
- (11) Long-term care benefits including home care, skilled nursing care, and respite care, are excluded except as a participating health plan shall determine they are less costly alternatives to the basic minimum benefits.

- (12) Dental services and services for temporomandibular joint problems are excluded, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible.

This language shall not be construed to exclude surgical procedures for any condition directly affecting the upper or lower jawbone, or associated bone joints.

- (13) Treatment of chemical dependency except as specified in section 2698.301(a)(1)(J).

- (14) Cosmetic surgery, except as specifically provided in section 2698.301(a)(6).

- (15) Maternity care for a subscriber who (a) enrolled in the program with an effective date on or after February 1, 2012, and (b) has entered into an agreement to serve as a paid surrogate mother. For purposes of this section, an agreement to serve as a paid surrogate mother is an agreement entered into, in advance of the pregnancy, under which the subscriber agrees to become pregnant and deliver a child for another person as the intended parent, in exchange for monetary compensation other than actual medical or living expenses.

- (b) Benefits which exceed \$75,000 in a calendar year under the program for a subscriber, a subscriber's enrolled dependent or a dependent subscriber shall be excluded.
- (c) Benefits which exceed \$750,000 in a lifetime under the program for a subscriber, a subscriber's enrolled dependent or dependent subscriber shall be excluded. Benefits received prior to January 1, 1999 shall be counted toward the \$750,000 lifetime maximum.

Note: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12712, Insurance Code.